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ABSTRACT

Under the State Children's Health Insurance Program (SCHIP), states have the option to subsidize employer premiums for low-income workers with children. Given the potential for subsidized employer-sponsored insurance (ESI) programs to reduce the number of uninsured children, this study examined SCHIP's regulations and state experiences with premium assistance programs. In addition to a literature review, three states, Massachusetts, Mississippi, and Wisconsin, were selected for in-depth examination. Data were collected through telephone interviews with officials from each state and from the Centers for Medicare and Medicaid Services regarding the impact of SCHIP regulations, state implementation experiences, and lessons learned. Findings revealed that although state officials viewed premium assistance as a worthwhile means of expanding health coverage, the experiences of Massachusetts and Wisconsin suggest that subsidizing ESI programs is administratively complex due to federal requirements addressing concerns about crowd out--the potential that SCHIP might displace private insurance coverage. These states found that outreach efforts had to be augmented with specific efforts targeting employers. Enrollment procedures were complex, time-consuming, and challenging, especially the requirements to compare employee benefit packages to the state-selected SCHIP benchmark. Massachusetts and Wisconsin officials cautioned other states from being overly optimistic about initial enrollment, with Wisconsin's enrollment currently at 47 families. Mississippi had yet to implement its program, but state officials were optimistic that it is a worthwhile strategy within the

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broader context of expanding health coverage. It was concluded that it is reasonable for states to question the efficiency of this strategy for reducing the number of uninsured among low-income children, given the limited target population and the small likelihood that federal regulations for premium assistance under SCHIP will be relaxed. (Contains 25 endnotes and 24 references.) (KB)

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Premium Assistance Programs under SCHIP

Not for the Faint of Heart?

Amy Westpfahl Lutzky
Ian Hill

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Occasional Paper Number 65

Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

SCHIP
State Children's Health Insurance Program Evaluation

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SCHIP
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This report is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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About the Series

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

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Foreword

This is one of a series of reports exploring policy issues that have emerged during states' early implementation of the State Children's Health Insurance Program, or SCHIP. These reports seek to identify important challenges states have faced, explore the availability of data to analyze these issues, provide initial analysis of the effects of alternative policies and implementation strategies, and raise questions for further study. Because of the limited scope of these analyses, it is important to exercise restraint in drawing conclusions from study results; these reports are intended to provide preliminary analyses of complex issues, and early insights into their nature and possible resolution.

The authors would like to extend sincere thanks to the many people who assisted with the completion of this project. Caroline Taplin, our project officer at the Office of the Assistant Secretary for Planning and Evaluation (ASPE), DHHS, provided strong guidance and support through the paper's development. In addition, we would like to thank the other ASPE officials involved in the paper's development (Tanya Alteras, Steven Finan, Julia Paradise, Barbara Richards, Adelle Simmons, and Jennifer Tolbert) for their helpful feedback.

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Executive Summary

Under the State Children's Health Insurance Program (SCHIP), passed in 1997, states have the option to subsidize employer premiums for low-income children, and in some cases, their parents.[1] Providing families with premium assistance may be a viable means of covering more uninsured children because this country's health insurance system is dominated by employer-based coverage. In addition, the majority (over 80 percent) of uninsured Americans are either workers or live with workers—although many do not have access to employer-sponsored insurance (Garrett, Nichols and Greenman 2001). Nevertheless, given the potential for subsidized employer-sponsored insurance (ESI) programs to reduce the number of uninsured children, the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the Urban Institute to conduct a study examining SCHIP's regulations and state experiences with premium assistance programs.

For this study, three states—Massachusetts, Mississippi, and Wisconsin—were selected for in-depth examination because, until recently, they were the only states with federally approved programs.[2] Our study included a literature review, an examination of relevant SCHIP regulations, and a review and analysis of relevant information collected from the Urban Institute's SCHIP evaluation—conducted as part of the *Assessing the New Federalism* project. However, the majority of information for this study was collected during telephone interviews with program officials from the three states and an official from CMS, using a standardized protocol to ensure consistency. The protocol primarily focused on the impact of SCHIP regulations, state implementation experiences, and lessons learned. It was anticipated that this study would contribute to a better understanding of the opportunities and limitations of premium subsidy programs and assist other states in assessing the feasibility of adopting premium assistance programs under SCHIP.

While states were afforded considerable flexibility in the overall design of their SCHIP programs, proposed federal requirements for designing premium assistance programs were very specific because of concern about crowd out—the potential that SCHIP might displace private coverage. Consequently, proposed federal requirements, published in November 1999, specific to premium assistance programs were established to limit the potential for crowd out and assure children a comprehensive benefit package. These requirements included

- a six-month waiting period,
- a requirement that employers contribute at least 60 percent of the premium cost,[3]
- a test to determine whether it is cost-effective to cover an uninsured child (and potentially parents) under ESI rather than directly enrolling him or her in SCHIP, and

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- a requirement that states continue to extend the minimum benefits and cost-sharing protections established under SCHIP statute for direct coverage programs to persons enrolled in premium assistance programs.[4]

The proposed requirements were viewed as administrative burdens by many states and, consequently, few states implemented premium assistance programs under SCHIP. In response to numerous comments regarding the November 1999 proposed rules, CMS issued proposed final rules in January 2001.[5] These proposed final rules largely maintained existing policy, although in some areas the new rules afforded states additional flexibility with respect to premium assistance programs. Of note, federal officials dropped the 60 percent contribution rule, deciding that it was unnecessary given that a substantial employer contribution must be made in order for a state-subsidized plan to be found cost-effective. Instead, CMS instructed states to identify a reasonable minimum employer contribution level representative of the state's ESI market and to monitor ESI contribution levels over time to determine whether crowd out is occurring.

Even with constraining federal requirements, there are a number of reasons why states might want to consider expanding children's health insurance through premium assistance programs. Among the three states examined in this study, the primary reasons identified by state officials for subsidizing employer-sponsored insurance were similar and included

- interest in expanding health coverage to working families who could not afford to take up offers of employer-sponsored insurance;
- the opportunity to leverage private funding "already in the system" to better maximize the use of financial resources available for health coverage; and
- deterring the likelihood that SCHIP would crowd out private health insurance coverage.

This last rationale is particularly interesting in light of the federal concern that premium assistance programs pose a *greater* potential for crowd out than direct coverage public programs (HCFA 1998). All three states we studied viewed such programs as a means of encouraging families to take up or maintain ESI, and as a vehicle for supporting an employer commitment to ESI.

Although the states in our study believed in premium assistance as a worthwhile means of expanding health coverage, the experiences of the two states with implementation experiences—Massachusetts and Wisconsin—suggest that subsidizing ESI programs is administratively complex, and according to one official, "not for the faint of heart." The premium assistance programs examined in this study suggest several findings that may be useful to other states considering such programs.

- **Outreach.** Although states have recently gained considerable experience in targeting public program outreach efforts to families and community-based organizations, premium assistance programs pose a new outreach challenge to states as they directly involve and require the cooperation of employers. To succeed in implementing premium assistance programs, state officials noted the importance of augmenting broader SCHIP outreach campaigns with specific efforts to target

employers, and involving employers in the design phase to address their concerns and ensure their participation.

- **Enrollment.** Wisconsin and Massachusetts have learned they must engage in complex, time-consuming, and challenging processes for enrolling children (and often their parents) into premium assistance programs. Typically these processes involve determining access to ESI, reviewing and comparing the benefit packages offered by employers to the health benefit coverage the state has chosen as its benchmark,[6] determining employer contributions to the overall cost of coverage, and calculating whether it is cost-effective to subsidize ESI or enroll the child into a direct coverage SCHIP program. In particular, state officials noted that the complexity of investigating employer benefit packages and comparing them to the state-selected SCHIP benchmark has resulted in families not qualifying for premium assistance largely due to plans not covering benefits such as dental and vision.

- **Outcomes.** Massachusetts and Wisconsin believe their premium assistance programs are worthwhile endeavors, but caution other states considering such programs from being overly optimistic about initial enrollment. As of October 31, 2001, enrollment in Wisconsin's Health Insurance Premium Payment (HIPP) program consisted of 47 families, a very small number given Wisconsin's overall SCHIP enrollment. As of September 30, 2001, the number of children receiving premium assistance in Massachusetts totaled 4,433, but only 16 percent were funded through SCHIP because of the stringency of their SCHIP benefit benchmark (with the remainder funded through Medicaid). Massachusetts is hoping that recent federal approval, granted in March 2002, of a plan amendment to change its current SCHIP benchmark benefit plan to the "Secretary-approved" coverage that was approved in its Medicaid 1115 demonstration waiver, will allow greater numbers of children to qualify for SCHIP-funded premium assistance.

Despite relatively small numbers of enrolled families, Massachusetts and Wisconsin officials are comfortable with the progress their programs have made thus far, even given the administrative difficulties and additional outreach efforts required. They have placed these programs in the broader context of expanding health coverage and believe that partnering with the private sector "is the right thing to do" and will have long-term benefits. Moreover, Massachusetts points to the number of children receiving Medicaid-funded premium assistance (3,733 children) as evidence that federal requirements hinder the enrollment of SCHIP-funded participants (700 children). Although Mississippi has yet to implement its program, state officials are optimistic that it is still a strategy worth pursuing as a means of expanding coverage and stemming crowd out.

Considering the administrative complexity associated with premium assistance and small overall effect witnessed in Massachusetts and Wisconsin, it seems reasonable for states to question whether this is an efficient strategy for reducing rates of uninsurance among low-income children. At this time, it appears unlikely that federal regulations for premium assistance under SCHIP will be further relaxed given the uncertainty and lack of data on crowd out, although states may have more flexibility in designing premium assistance programs under the new Health Insurance

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Flexibility and Accountability (HIFA) demonstration initiative. Nevertheless, the complexity of coordinating coverage with employers, the shifting nature of low-income families' employment status, and the dynamic nature of employer-sponsored insurance, remain potential barriers to enacting such programs (Polzer 2000). In addition, it is important to keep in mind that these programs have a limited target population—uninsured, low-income families that have not taken up offers of employer-sponsored coverage; premium assistance programs do not help uninsured families that have not received offers of health insurance from their employers. States will need to weigh these negatives against the positive impact premium assistance programs may have on expanding or maintaining health insurance coverage within the employer-based market. Unfortunately, these complex considerations must occur within the current recessionary environment—when increased demands for subsidies are coupled with declining state revenues and rising Medicaid costs.

Premium Assistance Programs under SCHIP

Not for the Faint of Heart?

Background

Concern for the nation's 10.7 million uninsured children prompted policymakers, government officials, and advocates to develop the State Children's Health Insurance Program (SCHIP) in 1997. Since then, all states have implemented SCHIP programs. As of June 2000, 2.7 million children were enrolled in SCHIP (Smith, Rousseau, and Guyer 2001); during the first quarter of federal fiscal year 2002, 3.7 million children were "ever enrolled" in the program (CMS 2002). Despite the progress states have made in enrolling children in SCHIP and Medicaid, 6.5 million low-income children remain uninsured—84 percent of which are eligible for Medicaid or SCHIP (Dubay, Haley, and Kenney 2002). Thus, there is considerable room for additional efforts to enroll these eligible children into public programs. States have focused on outreach initiatives and streamlining enrollment processes, and more recently, have turned their attention to improving the rates of retention among eligible children (Hill and Lutzky 2003). However, a few states have pursued another option permitted under SCHIP to reduce the number of uninsured children—premium assistance, also known as subsidizing employer-sponsored insurance (ESI).

Title XXI (SCHIP) allows states to subsidize employer premiums for low income children, and in some cases, their parents.[7] Providing families with premium assistance may be a viable means of covering more uninsured children because this country's health insurance system is dominated by employer-based coverage. In addition, the majority (over 80 percent) of uninsured Americans are either workers or live with workers (Garrett, Nichols, and Greenman 2001). These uninsured workers and family members lack coverage for two primary reasons—access and affordability.

With regard to access, workers may be uninsured because their employer does not offer coverage. This is particularly true for those who have part-time jobs, work in small firms, and work in agriculture, retail, construction, or the service industry (Garrett et al. 2001). Moreover, parents working in low-wage jobs are less likely to receive an offer of employer health coverage than higher-income families—59 percent of working parents earning below 200 percent of the federal poverty level (FPL) receive an offer of ESI, compared with 86 percent of working parents earning above 200 percent of FPL (February Supplement, 1999 Current Population Survey).

Even workers who are offered coverage, however, may be uninsured because the cost of purchasing employer coverage is unaffordable. For example, while high-

income workers tend to decline an ESI offer because of access to other coverage (typically through a spouse), low-income workers appear to decline ESI because of the high cost of coverage. Data show that such workers are more likely to remain uninsured: 59 percent of low-income workers with children declining ESI remain uninsured, compared with 25 percent of high-income workers with children declining ESI (February Supplement, 1999 CPS). Affordability is a particularly acute problem for workers in small firms because small employers tend to provide less generous benefit packages and require more cost-sharing than large employers (Nichols et al. 1997).

While premium assistance programs can't help those families whose employers don't offer health insurance, they can assist families who previously couldn't afford employer-sponsored insurance when it was offered to them. States may also want premium assistance for other reasons, including

- decreasing uninsurance by appealing to some working families that might resist enrolling their children in a public health insurance program because they associate it with welfare;
- allowing states to maximize financial resources and cover uninsured children by combining federal and state funds with employer contributions already "in the system;"
- enabling states to support welfare reform by strengthening low-income employee ties to the workforce; and
- building on the existing private insurance market.

Although there are a number of reasons why states may consider implementing premium assistance programs, it is important to note that such programs have a narrow band of eligibility—low-income families that have received, but declined, offers of employer-sponsored coverage. Premium assistance programs do not help the many low-income working families without access to family coverage.

SCHIP federal regulations further narrow the population likely to benefit from premium assistance by establishing specific criteria that employer plans must meet before employees can qualify for the subsidy. In order to limit the potential for crowd out and to assure that children received a comprehensive benefit package, federal requirements for designing premium assistance programs were very specific, and included

- a six-month waiting period,
- a requirement that employers contribute at least 60 percent of the premium cost,[8]
- a test to determine whether it is cost-effective to cover an uninsured child (and potentially parents) under ESI rather than directly enrolling them in SCHIP, and
- a requirement that states continue to extend the minimum benefits and cost-sharing protections established under the SCHIP statute for direct coverage programs to persons enrolled in premium assistance programs.[9]

These federal requirements were viewed as quite limiting by many states and, consequently, few states implemented premium assistance programs under SCHIP. As of March 2002, seven states submitted ESI plans to the Centers for Medicare and Medicaid Services (CMS) and only four of these had been implemented. Some policymakers and government officials hope that more interest in premium assistance programs will develop with the elimination of the 60 percent employer contribution requirement in the final SCHIP rules and the recent flexibility afforded to states under the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. HIFA, a newly developed Medicaid and SCHIP section 1115 waiver approach, provides states with additional flexibility regarding the modification of benefits for optional Medicaid and SCHIP populations and even greater flexibility in designing benefit packages for expansion populations.

This paper examines the opportunity under Title XXI to subsidize ESI and the experiences of three states in designing and implementing ESI programs.[10] First, this study discusses the federal rules for subsidized ESI programs, and in particular, explores those requirements states find limiting. Second, it focuses on the experiences of Massachusetts, Wisconsin, and Mississippi—examining the state's reasons for developing a premium assistance program, the employer-based insurance market in each state, and the "nuts and bolts" of each program with emphasis on the state's operational experiences and lessons learned. Lastly, the study discusses the implications of these states' experiences for other states considering premium assistance programs under SCHIP.

Study Methods

The U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the Urban Institute to conduct a study examining SCHIP's regulations and state experiences with premium assistance programs. It was anticipated that this study would contribute to a better understanding of the opportunities and limitations of premium assistance programs and help other states assess the feasibility of such programs under SCHIP.

We selected three states—Massachusetts, Mississippi, and Wisconsin—for in-depth examination because, until recently, they were the only states with federally approved programs.[11] We began by conducting a literature review of existing studies examining premium subsidy programs and studying the federal regulations regarding such programs. We then assembled relevant information collected from the Urban Institute's SCHIP evaluation, conducted as part of the *Assessing the New Federalism* project. The majority of information for this study was collected during telephone interviews with program officials from Massachusetts, Mississippi, and Wisconsin, and an official from CMS. The interviews were conducted using a standardized protocol to ensure consistency. The protocol confirmed previously collected information on the basic structure of the state's premium assistance program, but primarily focused on state implementation experiences, lessons learned, and the possible effects of the revised SCHIP regulations on reducing administrative burden.

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Federal Requirements for Subsidizing ESI under SCHIP

Proposed Federal Rules

While states were afforded considerable flexibility in the overall design of their SCHIP programs, more specific guidelines were laid out for states wishing to expand children's coverage through subsidies of employer-sponsored insurance. In a February 1998 letter to state health officials, CMS suggested that it would apply particular scrutiny to these programs because of their perceived greater potential to cause crowd out.

Crowd out was one of the more contentious issues surrounding development of the SCHIP legislation. Crowd out may occur when parents drop dependent coverage to enroll their child in subsidized health coverage, or when a previously uninsured parent whose child is enrolled in public coverage chooses to maintain that coverage and declines an offer of ESI. Crowd out may also occur when an employer deliberately reduces or eliminates health insurance coverage or subsidies for workers and their dependents expecting that available public programs will provide health coverage (Lutzky and Hill 2001).

Based on research suggesting that Medicaid expansions for pregnant women and children in the late 1980s and early 1990s may have crowded out some private health insurance coverage, federal policymakers believed that SCHIP might create additional opportunities for employers and employees to pass on their health insurance costs to the government. These concerns resulted in the requirement that states choosing to create separate children's health insurance programs must implement procedures to reduce the potential for substitution (Lutzky and Hill 2001).

Policymakers' concern about the potential for SCHIP to crowd out private insurance was heightened when it came to the option of subsidizing employer premiums under SCHIP. There has been a greater concern over crowd out for premium assistance programs than direct coverage programs because premium assistance programs target working families—leading to the belief that there is a greater likelihood that employers may reduce or eliminate their premium contributions for dependent coverage, or that families will take advantage of premium assistance programs for coverage they would have purchased with their own income. Moreover, federal policymakers and government officials believed that lower income families might actually be more likely to replace their ESI contribution with premium subsidies than higher income families because of their higher cost of insurance relative to income (Federal Register 1999). To limit the potential for crowd out and to assure that children receive a comprehensive benefit package, proposed rules required that states meet the following provisions in their plans for premium assistance (HCFA 1998; Federal Register 1999):

- **Minimum benefit and cost-sharing provision established under SCHIP.** Premium assistance programs were required to assure the minimum benefits and cost-sharing protections established by the SCHIP statute, either through the employer plan or as a supplement to the employer plan.

- **Six-month waiting period.** To ensure that coverage was targeted to children in families that were previously unable to afford dependent coverage, states were required to deny SCHIP for children who had employer-sponsored insurance within the previous six months, unless their coverage was involuntarily terminated.
- **Sixty percent employer contribution**. To discourage employers from reducing their existing contributions, states were permitted to subsidize ESI only in cases where the employer contributed at least 60 percent toward the cost of family coverage.
- **Cost-effectiveness test.** To ensure that subsidizing ESI was cost-effective, a state's subsidy for a child enrolled in an employer-sponsored group health plan could be no greater than the payment that the state would make for the child if he or she were enrolled in the direct coverage portion of the SCHIP plan offered by the state. If a state wished to subsidize family, rather than child coverage only, the state was required to apply for a family coverage amendment.[12]
- **Monitoring substitution.** States were also required to monitor the amount of substitution occurring under their programs, as well as the effects of these programs on access to the program.

States perceived these proposed regulations as unrealistic, given the anticipated administrative burden and the improbability that employers in many states would meet the required criteria. States expected that the processes required to perform cost-effectiveness tests and compare employer benefit packages and cost-sharing arrangements to those of the approved minimum requirements would be time- and resource-intensive. In addition, despite identified studies that showed that employers generally contribute two-thirds of the cost of family coverage some states maintained that the 60 percent contribution rule was not appropriate to their particular demographic and market characteristics, particularly for SCHIP's low-income target population (Federal Register 1999). Moreover, some states believed that not only were many employers contributing less than 60 percent of the cost of coverage, but that their benefit packages would be too limited and cost-sharing too high to meet the SCHIP requirements (Polzer 2000). Adding to these specific objections, many state officials believed that the potential for crowd out was small to begin with, and that such stringent requirements were unwarranted (Lutzky and Hill 2001). Lack of evidence to support or reject apprehension over SCHIP's potential to displace private coverage further fueled states' frustration over the federal regulations.

Consequently, only a handful of states presented CMS with plans for premium assistance programs. Massachusetts worked around the stringency of some of the regulations by using its Medicaid Section 1115 demonstration waiver to fund those children not eligible under SCHIP regulations. However, an agreement was not reached over Florida's premium assistance plan, which proposed to vary minimum requirements for employer contribution levels by company size.[13] Other states considering ESI programs were vocal in their frustration over federal requirements and several, such as Illinois and Oregon, after weighing the alternatives, opted to use state funding to implement premium assistance programs rather than apply for fed-

eral SCHIP matching funds. Moreover, states weighing the administrative costs of premium assistance against its limited target population (low-income workers who declined offers of *qualifying* employer-sponsored coverage) may have decided that it was not a viable strategy for reducing the number of uninsured children. For example, Colorado is reluctant to design a premium assistance program because estimates suggest that even if federal requirements were eliminated, only 4,500 children would be eligible and the program would require an annual administrative budget of over $1 million (Schulte et al. 2001).

Final Rules

In response to numerous comments regarding the November 1999 proposed rules, CMS issued final rules in January 2001.[14] These proposed final rules largely maintained existing policy, although in some areas, such as premium assistance, the new rules afforded states additional flexibility by

- **dropping the 60 percent employer contribution rule.** It was decided that this requirement was unnecessary given that a substantial employer contribution must be made in order for a state subsidized plan to be found cost-effective. In addition, several states had commented that the 60 percent level was too high. Instead, CMS opted to eliminate the 60 percent employer contribution and instructed states to identify a reasonable minimum employer contribution level representative of the state's ESI market and to monitor ESI contribution levels over time to determine whether crowd out is occurring.
- **clarifying waiting period rules.** Although the six-month waiting period still stands, CMS clarified that states may establish "reasonable" exceptions to the waiting period.

Implementation Experiences

This section describes the experiences of Massachusetts, Wisconsin, and Mississippi in designing and, in the case of Massachusetts and Wisconsin, implementing their premium subsidy programs. Specifically, it examines each state's motivation and genesis for premium subsidy programs, as well as its target population and ESI market characteristics. The program policies and procedures are then reviewed, with emphasis placed on each state's implementation experience and lessons learned.

Massachusetts

Overview of Program

Massachusetts' Family Assistance Program is one of six main constituent programs under MassHealth, the state's constellation of coverage plans that use Medicaid, SCHIP, and state-only funding to provide health coverage to low-income residents (Bovbjerg and Ullman 2002). The Family Assistance program provides coverage for

children with incomes between 150 and 200 percent of FPL. For families with access to ESI, the Premium Assistance component of the Family Assistance program subsidizes the child's premiums (parents are often covered incidentally when the state subsidizes a family premium to cover the children) with SCHIP matching funds under the following conditions:

- Children are previously uninsured and living in families earning between 150 and 200 percent of FPL;
- The family's ESI plan meets the defined benchmark plan;[15]
- The employer contributes at least 50 percent to the cost of coverage; [16] and
- It is cost-effective for the state to subsidize ESI rather than enrolling the child into the direct coverage component of MassHealth.

Importantly, if children in families with incomes between 150 and 200 percent of FPL are already insured or have parents whose ESI fails to meet the defined SCHIP benchmark plan, they may still receive ESI subsidies in the Family Assistance Premium Assistance program, but are covered by Medicaid (as opposed to SCHIP) under the state's Section 1115 demonstration waiver. Massachusetts does not have a waiting period whereby children must be uninsured for a required period of time before being eligible for the program. Children with incomes at or below 150 percent of FPL may receive ESI subsidies in the MassHealth Standard program, and are covered by SCHIP matching funds if they are uninsured and their offered coverage meets the required criteria—otherwise they are covered by Medicaid matching funds. If children do not have access to employer-sponsored insurance, the state offers them direct coverage through MassHealth Standard if they are at or below 150 percent of FPL, or through the Family Assistance program if their income is above 150 percent of FPL. (Table 1 details the eligibility requirements for premiums assistance under the Family Assistance Program and MassHealth Standard).

The Family Assistance program also has an adult component that uses Medicaid funding. Unlike the children's program, the adult program excludes workers at larger firms and does not offer direct MassHealth coverage for those without access to ESI. Under the adult Premium Assistance program, subsidies are provided to parents (133–200 percent of FPL) and childless adults (0–200 percent of FPL) working in firms with 50 or fewer full-time employees.

The Massachusetts Premium Assistance program is run by the Division of Medical Assistance (DMA), which contracts out many of the administrative functions to three vendors, depending on the employer size and whether they participate in the state's Insurance Partnership program. The Insurance Partnership program provides incentives to small employers to maintain or begin ESI coverage.[17] For firms participating in the Insurance Partnership program with between 10 and 50 employees, administrative responsibilities are handled by the Employee Benefit Resources Insurance Brokerage, Inc. (EBR), a private brokerage firm. Billing and Enrollment Intermediaries (BEIs), private entities regulated by state legislation to sell health coverage to very small businesses and provide administrative support, handle the administrative responsibilities for firms with fewer than 10 employees

Table 1. Program Criteria and Federal Funding Sources for Children's Premium Assistance under MassHealth Standard and the Family Assistance Program

Program	Federal funding source	Uninsured	Benchmark benefit[a]	Employer contribution ≥ 50%	Cost-effective
MassHealth Standard, income ≤ 150% of FPL	Title XXI (SCHIP Medicaid expansion)	▶	▶	▶	▶
	Title XIX (Medicaid)			▶	▶
Family Assistance, income > 150% FPL	Title XXI (SCHIP separate program expansion)	▶	▶	▶	▶
	Title XIX (Medicaid)			▶	▶

Source: Interviews with state workers.

a. In MassHealth Standard Premium Assistance, ESI coverage does not need to meet the benchmark benefit standard because the state will provide wraparound coverage to ensure that children receive the full array of benefits available to children in MassHealth Standard.

that participate in the Insurance Partnership program. The majority of the insurance investigations are conducted by PCG, a private vendor. PCG conducts insurance investigations for all firms, regardless of size, that do not participate in the Insurance Partnership program.

History of Policy Development. The development of Massachusetts' Premium Assistance program is not surprising given the state's long history of support of government programs, including a strong public sector commitment to health services for the low-income population. The program was originally called the Insurance Reimbursement Program and was designed as part of the state's Section 1115 MassHealth waiver request, which was submitted to CMS in 1994. The program was spearheaded by the Division of Medical Assistance and received strong support from the governor. The 1115 Waiver plan included a restructuring and expansion of the state's Medicaid program and the creation of the Insurance Reimbursement Program, which would provide employee subsidies and employer tax credits to encourage offers and take-up rates of employer-sponsored insurance. The program was intended to improve access to health insurance and to reduce costs to the state's uncompensated care pool by subsidizing ESI coverage (Holahan et al. 1998). In addition, it was believed that the program would help support an employer commitment to ESI.

Massachusetts received federal approval for the waiver in 1995, but did not begin offering premium assistance until 1998. While the administration wanted to provide a strong incentive for employers either to begin or retain coverage for low-income workers, some legislators believed that subsidizing ESI would crowd out existing private coverage and provide subsidies at public expense to individuals who would have purchased coverage on their own (Holahan et al. 1998). In addition, passage of SCHIP and its opportunity for subsidizing ESI caused further delay as the state worked out the details of folding SCHIP into its MassHealth expansion plans. Massachusetts decided to use SCHIP funding for a combined Medicaid and

non-Medicaid coverage expansion to extend health insurance to children in families earning up-to 200 percent of FPL. Massachusetts received federal approval of its SCHIP plan in May 1998 and implemented the Medicaid and non-Medicaid MassHealth expansion shortly thereafter. But the Premium Assistance program was implemented in several phases owing to its complexity. The initial phase was limited to low-income children in 1998 and then expanded to include adults in 2000.

Target Population and ESI Market Characteristics. Massachusetts is a wealthy, high growth, heavily urbanized state, with a lower rate of uninsured residents than the national average (Bovbjerg and Ullman 2002). In 1999, 3.4 percent of children were uninsured compared with 12.5 percent nationally and 8.3 percent of adults were uninsured compared with 16.3 percent nationally (Kenney, Dubay, and Haley 2000; Zuckerman, Haley, and Holahan 2000). Although the state's low rates of uninsurance are attributed to generous public program coverage, Massachusetts also has a higher than average rate of employer-sponsored insurance—72.9 percent for children compared with 66.7 percent nationally, and 79.1 percent for adults compared with 72.3 percent nationally (Kenney et al. 2000; Zuckerman et al. 2000; Zuckerman et al. 2001). However, among low-income residents, employer-sponsored insurance is lower than the national average, particularly among children—32.2 percent of children are covered under ESI compared with 38.7 percent nationally (Kenney et al. 2000; Zuckerman et al. 2000). At the onset of the program, Massachusetts estimated that there were approximately 70,000 to 100,000 individuals (with and without children) who worked for small employers and had incomes less than 200 percent of FPL as a proxy for the target population of the PA program.

Large establishments are more likely to offer coverage in Massachusetts than small establishments. Among establishments with 50 or more employees in 1998, 97.5 percent offered ESI, compared with 54.4 percent among establishments with fewer than 50 employees. The percentage of establishments that are classified as "large" or "small" is comparable with the national average—78.1 percent of businesses are "small" whereas 21.9 percent are "large" (Agency for Healthcare Research and Quality 1998). Workers least likely to be uninsured were employed in government, transportation, communication, and utilities, while workers in agriculture/mining and self-employed workers had the highest uninsured rates (Employee Benefit Research Institute 2001).

Operation Procedures and Implementation Experiences

Outreach and Enrollment. The Premium Assistance program has primarily been identifying participants through the MassHealth joint Medicaid and SCHIP application. Thus, broad MassHealth outreach efforts have been serving to draw participants into the Premium Assistance Program. However, the state has also conducted outreach specific to the those eligible for premium assistance. In 2000–2001, to increase awareness of the Premium Assistance program among the business community, the state ran newspaper advertisements in the Boston Globe. By promoting the message that they were "not selling insurance, but helping families to pay for it," the state found the advertisements quite successful. In addition, the state met with Chambers of Commerce and local business groups to promote the program to employers.

Outreach to very small firms is contracted out to the BEIs and outreach to firms with between 10 and 50 employees is contracted out to EBR. Specific outreach efforts have included (Silow-Carroll, Waldman, and Meyer 2001):

- Mailings to insurance brokers and insurance companies;
- Contacts with Chambers of Commerce;
- Radio announcements;
- Television commercials;
- Mailings to nonprofit organizations with fewer than 50 employees;
- Calls to small businesses by regional representatives;
- Telephone cold calls followed with literature mailings to interested employers;
- Print media (newspaper advertisements); and
- Billboard advertisements.

Massachusetts has found the health insurance investigation process more administratively complex than anticipated. As mentioned above, the process begins with the Division of Medical Assistance (DMA) reviewing the MassHealth joint Medicaid/SCHIP application. Eligibility is initially determined for MassHealth Standard (children with income at or below 150 percent of FPL) or Family Assistance (children with income above 150 percent of FPL). Subsequently, all of the Family Assistance eligibles are screened for access to private insurance coverage. There is a question on the application that specifically asks the applicant about ESI availability. However, an independent check is also conducted. MassHealth Standard eligibles are not automatically screened for access to private insurance coverage, but are reviewed upon request of the participant.

One of the private vendors (either PCG, EBR, or BEI) then conducts the health insurance investigation process. The process is essentially the same across the three vendors—with the exception that BEIs and EBR do not need to investigate their employers' benefit packages because employers participating in the Insurance Partnership program must already meet a basic benefit level, as defined by state regulation of small group insurance. The primary steps for health insurance investigation are summarized below:

- **Benefit comparison.** PCG performs a side-by-side comparison of the ESI benefits to the SCHIP benchmark benefit plan (the largest HMO in the state, Harvard Pilgrim). If the child's ESI fails to meet the SCHIP benchmark benefit plan, but meets or exceeds the basic benefit package under the state's Medicaid 1115 waiver, then the child is funded through Medicaid rather than SCHIP. In Massachusetts' 1115 demonstration waiver, the basic benefit level is defined as comprehensive coverage that includes the mandated benefits in the state's small group insurance market. In MassHealth Standard Premium Assistance, the state will provide wraparound coverage to ensure that children receive the same comprehensive Medicaid benefits in their ESI plan as they would in direct-coverage MassHealth Standard. The state does not provide wraparound benefit coverage in the MassHealth Family Assistance program.

It is easier for an ESI plan to meet the basic benefit package than the SCHIP benchmark plan for two reasons: 1) the basic benefit package is less comprehensive than the SCHIP benchmark (for example, it does not include coverage for prescription drugs); and 2) the state performs a side-by-side comparison with the SCHIP benchmark plan such that each ESI benefit must either match or be more generous than the benchmark. The side-by-side benefit comparison is very difficult to meet because the benefits must be equivalent or exceed the benchmark. For example, if a plan covers $2,400 worth of durable medical equipment, but the SCHIP benchmark covers $2,500 worth, the ESI plan fails the SCHIP benefit criteria. To simplify this process, Massachusetts will implement its recently approved plan amendment that will change its SCHIP benchmark benefit into "Secretary-approved" coverage, that is, the comprehensive coverage for children offered under its approved Title XIX section 1115 demonstration waiver.

- **Employer contribution level.** Once the employer's benefit package is reviewed, the vendor then determines whether the ESI plan meets the cost-sharing requirements under SCHIP, including the requirement that employers must contribute at least 50 percent to the cost of the offered health insurance premium. Despite the change in federal regulations, Massachusetts has not opted to reduce its employer contribution level below the 50 percent level that was agreed upon in its Medicaid 1115 demonstration waiver.

- **Premium determination and cost-effectiveness test.** The state first determines what the family's premium level would be based on the family's income. Families with children and incomes below 150 percent of FPL are not required to pay a portion of the monthly premium; those over 150 percent of FPL share the cost of the premium (a flat amount based on the number of children, ranging between $10 and $30). This required family contribution level, along with the total health insurance premium, is used to determine the state's subsidized portion. This is done by subtracting the employer contribution and family share from the total health insurance premium. Then, the cost-effectiveness test is conducted—the estimated premium assistance payment is compared to the cost of covering the eligible children with MassHealth direct coverage.

The entire eligibility review process must be completed within 60 days for uninsured applicants that have potential access to insurance. There is a maximum of 45 days for applicants that self-declare that they have insurance already.[18] Typically, the review process is completed in much less time, with the review for potential access to insurance taking 5–6 days and the review of those with self-declared access to insurance taking 3–4 days (State Coverage Initiatives 2001). While the eligibility review process is being conducted, those applicants without insurance coverage are granted presumptive eligibility and provided with fee-for-service coverage for up to 60 days. Approximately one in four children with incomes between 150 and 200 percent of FPL qualify for premium assistance, but the majority of these children are funded through the state's Medicaid 1115 demonstration waiver, rather than SCHIP.

Payment Processes. Coverage under the Premium Assistance Program begins once the employee provides one of the following documents demonstrating that

the child is enrolled in ESI: an enrollment form, a letter from the employer saying the child is enrolled, or a pay stub showing withholding for insurance. Enrollees receive subsidies directly from the Division of Medical Assistance, except those in firms participating in the Insurance Partnership program who receive subsidies through the BEIs or through EBR. Massachusetts decided to pay most of the Premium Assistance participants directly to minimize the employer's administrative burden and to enable families to receive coverage like other employees, thereby reducing the possibility that parents might feel awkward about openly participating in a government program (State Coverage Initiatives 2001). In addition to premiums, the program also covers certain copayments, co-insurance, and deductibles for well baby and well child visits, under certain conditions.[19] Massachusetts monitors participants' continued enrollment in ESI by conducting monthly audits.

Strategies to Address Crowd Out. Massachusetts officials believe that the Premium Assistance program may actually deter crowd out by helping employees afford private ESI health benefits. The state has described the PA program as part of its official strategy to deter crowd out in its SCHIP plan. Nevertheless, the state must take certain measures to limit the potential for crowd out as required by federal regulations, such as monitoring and reporting levels of substitution to CMS on a quarterly basis. Massachusetts monitors crowd out by randomly sampling those applicants who indicated that they had no access to insurance on their application and matches this information to an insurance carrier database. The degree of crowd out is measured as the percentage of applicants who had insurance within the previous six months. Because Massachusetts was granted federal approval for premium assistance under the Medicaid 1115 waiver before SCHIP, the SCHIP requirement for a waiting period was waived. In addition to monitoring crowd out, Massachusetts attempts to discourage employers from dropping or reducing their contribution to health insurance coverage through the Insurance Partnership program.

Lessons Learned

As of September 30, 2001, there were 4,433 children receiving premium assistance in both the MassHealth Standard Premium Assistance (657 children) and the Family Assistance Premium Assistance (3,776) programs. As shown in table 2, roughly 16 percent of these children were funded through SCHIP, with the vast majority funded by Title XIX under Massachusetts Medicaid 1115 demonstration project. Of note, Massachusetts primarily attributes the low number of SCHIP-funded participants to SCHIP's benchmark benefit requirement. As previously noted, for children to qualify for SCHIP-funded premium assistance, their ESI benefits must meet Massachusetts' benchmark benefit plan on a "side-by-side" comparison—a more difficult test than an actuarial analysis because the benefits must match almost exactly. Massachusetts is hoping that recent federal approval of a plan amendment to change its SCHIP benchmark benefit plan to the "Secretary-approved" coverage allowed in its Medicaid 1115 demonstration waiver will allow greater numbers of children to qualify for SCHIP-funded premium assistance.

Table 2 also shows that there are 3,451 adults in the Family Assistance Premium Assistance program, which is funded through Medicaid. This total does not

Table 2. Enrollment by Eligibility Group and Funding Source, September 30, 2001

	Medicaid-funded	SCHIP-funded	Total
Children, Family Assistance, Premium Assistance	3,733	43	3,776
Children MassHealth Standard, Premium Assistance		657	657
Adults, Family Assistance, Premium Assistance[a]	3,451		3,451
All eligibility groups	7,184	700	7,884

Source: Interviews with state workers.

a. Does not include adults that are incidentally covered.

include those adults that are incidentally covered, which state officials report total approximately 11,000.

In addition to the difficulties in meeting the SCHIP benchmark benefit requirement, there are several lessons that Massachusetts has learned over the program's duration worth noting:

- Although the state is able to cover parents incidentally in the PA program under the SCHIP match, this has resulted in some confusion among beneficiaries. When families receive a letter notifying them that they are eligible for the program, it states that the children are eligible for the MassHealth PA program. This has been confusing to parents as it is unclear that they also benefit from the subsidy by being incidentally covered. Now that CMS appears to be more open to considering parental coverage amendments under Title XXI, Massachusetts may consider amending their SCHIP-funded PA program to cover parents.
- Initially employers were skeptical of the program and it was important to increase employer recognition of the program through targeted outreach efforts. Because obtaining applicant information on ESI requires employer cooperation, it is important that employers are familiar with the program.
- Premium assistance has been seen as a valuable means of avoiding crowd out. Assisting families with maintaining their ESI (permissible under Massachusetts' 1115 demonstration, which does not require uninsurance as eligibility criteria) or with purchasing private coverage offered to them diminishes the likelihood that they will drop coverage to enroll in direct public coverage.
- Although maintaining a database of employer plans seemed like an efficient means of reducing the administrative burden of verifying and collecting ESI information, Massachusetts found that there have not been enough employees from the same firms to warrant the effort in keeping employer files current. Moreover, employer contribution and benefit packages change over time. Because calls are made to each employer for every new applicant into the program, it might be more efficient to have a database with only employers' contact information.

Despite the low number of children qualifying for SCHIP-funded premium assistance, Massachusetts believes that the required eligibility determination steps are worthwhile given the enhanced match, the objective of the program to assist families with purchasing private coverage, and the sizable number of premium assistance recipients that are funded through Medicaid. Nevertheless, Massachusetts

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underscored that premium assistance is a "different animal" than direct coverage through SCHIP or Medicaid. States interested in pursuing federal match for premium assistance should not be overly optimistic regarding initial enrollment because it takes time for outreach efforts to take effect and to gain credibility among employers.

Wisconsin

Overview of Program

Wisconsin's premium assistance program, the BadgerCare Health Insurance Premium Payment (HIPP) program, subsidizes coverage for families earning up to 185 percent of FPL.[20] Wisconsin, like Massachusetts, covers eligible parents as well as children. However, in contrast to Massachusetts (which provides premium assistance to eligible parents under a Medicaid 1115 waiver, or incidentally under SCHIP), Wisconsin receives enhanced SCHIP federal match for parents eligible for HIPP because of its recently obtained SCHIP waiver. To be eligible for the HIPP program, the following criteria must be met, in addition to the 185 percent of FPL income threshold:

- Families must be uninsured for the six months prior to application;
- The employer must contribute between 40 and 80 percent toward the cost of the premium;
- The ESI plan must meet the defined benchmark benefit plan; and
- It must be cost effective for the state to subsidize ESI rather than enroll the family directly into BadgerCare's direct coverage program.

History of Policy Development. As in Massachusetts, interest in developing an ESI program in Wisconsin predated the passage of SCHIP. In early 1997, Governor Tommy Thompson directed the Department of Health and Family Services to design a health care plan that would assist families leaving welfare and entering the workplace. Although spear-headed by the governor's office, backing for HIPP was bipartisan and the planning process included a variety of individuals and organizations, including state legislators, providers, managed care organizations, faith-based organizations, county government officials, and advocacy groups. State officials and others involved in the planning process supported the creation of HIPP because they believed a premium assistance program would reach more uninsured children than solely expanding coverage through a public program and that the state could achieve cost savings by creating a partnership with the private sector (State Coverage Initiatives 2001).

After submitting a Section 1115 Waiver request in October 1997 and later amending it to incorporate a SCHIP expansion in December 1998, Wisconsin received federal approval in January 1999 to implement its SCHIP program, BadgerCare, an expansion of the state's existing Medicaid program.[21] BadgerCare included HIPP. As mentioned earlier, Wisconsin elected to include adult coverage in their premium assistance program. Originally it was funded through a Medicaid

1115 waiver rather than through SCHIP because CMS would not permit SCHIP-funded adult coverage during the early stages of SCHIP implementation, preferring that states focus their initial expansions on children. In July 1999, the state began enrolling parents and children in families earning up to 185 percent of FPL into BadgerCare, including the HIPP program—with HIPP covering children through the enhanced SCHIP match and adults through the Title XIX match.[22] Wisconsin submitted an SCHIP 1115 amendment in March 2000. In January 2001, Wisconsin received approval to cover adults in HIPP through the enhanced SCHIP match.

Target Population and ESI Market Characteristics. Wisconsin, like Massachusetts, has a strong base of employer-sponsored health insurance coverage, a fairly extensive Medicaid program, and low numbers of uninsured people (Wiener and Brennan 2002). In 1999, 7.4 percent of children were uninsured compared with 12.5 percent nationally and 9.7 percent of adults were uninsured compared with 16.3 percent nationally (Kenney et al. 2000; Zuckerman et al. 2000). Wisconsin has a higher than average rate of employer-sponsored coverage—79.4 percent for children compared with 66.7 percent nationally, and 81.7 percent for adults compared with 72.3 percent nationally. Even among low-income families (earning under 200% of FPL), Wisconsin has a higher than average rate of ESI with 55.4 percent of children with employer coverage compared with 38.7 percent nationally, and 53.2 percent of adults with employer coverage compared with 41.7 percent nationally (Kenney et al. 2000; Zuckerman et al. 2000).

Consistent with the national trend, small businesses in Wisconsin are less likely to offer health coverage than large businesses. Among establishments with 50 or more employees, 98.0 percent offer their employees health coverage compared with 45.6 percent of establishments with less than 50 employees. The percentage of establishments that are classified as "large" or "small" is fairly comparable with the national average—78.9 percent are "small" and 21.1 percent are "large" (1998 Medical Expenditure Panel Survey – Insurance Component). Workers least likely to be uninsured were employed in government or construction, while workers in agriculture/mining and services industries had the highest uninsured rates (Employee Benefit Research Institute 2001).

Operation Procedures and Implementation Experiences

Outreach and Enrollment. As with Massachusetts, broader BadgerCare outreach efforts have been serving to draw participants into HIPP. In addition to the BadgerCare outreach campaign, Wisconsin has engaged in additional efforts to specifically raise awareness of HIPP in the form of brochures, posters, direct mailings to employers, and meetings with employer associations. In addition, the state has a hotline that employers or employees can call to get information about the program.

Wisconsin's eligibility determination process for HIPP begins with the state reviewing the joint SCHIP/Medicaid BadgerCare application. Wisconsin first reviews the applications for BadgerCare eligibility; if applicants are determined to be eligible, they are enrolled in the program. During this eligibility process, it is determined whether or not the family will be required to pay a premium based on their income. For those earning above 150 percent of FPL, the premium maximum

is 3 percent of family income.[23] No premium is required if income is at or below 150 percent of FPL. Once a family is in BadgerCare, the state determines if a family member is employed. If so, the application is forwarded to EDS, Wisconsin's contractor for HIPP administrative functions, to be screened for HIPP program eligibility.

EDS sends the employer a form, the Employer Verification of Insurance Coverage (EVIC), that asks questions about the health plans offered, benefits, cost of the plans, and the employer share of the premium. The primary steps for eligibility determination for HIPP then proceed as follows:

- **Benefit comparison.** To determine whether the employer's health plan meets the state's benchmark, an actuarial equivalence test is performed. The actuarial equivalence test looks at the employer plan versus the minimum (Health Insurance Portability and Accountability Act [HIPAA]) requirements in providing major medical coverage. The employer plan must also meet the HIPAA requirements for cost-sharing. Wisconsin provides wraparound coverage for the ESI plan to bring it up to the benchmark level, if it is cost-effective to do so.

- **Employer contribution level.** There is a 40 percent minimum contribution level and an 80 percent maximum level defined by a state legislative requirement. The state elected to impose an 80 percent maximum contribution level to prevent families with seemingly generous employer contributions to current coverage from taking advantage of the state program. Prior to November 2001, Wisconsin had a 60 percent employer contribution minimum, but as a result of changes to the final federal rule, the state was granted approval to lower their contribution level to 40 percent.

- **Cost-effectiveness test.** The state performs a cost effectiveness test to determine if it is cheaper to provide an ESI subsidy than to directly enroll the family in a BadgerCare HMO. In order to receive the enhanced SCHIP match for parents, the cost-effectiveness test must demonstrate that the cost of family coverage through ESI is less than the cost of covering the family in the BadgerCare HMO. If the family fails the SCHIP cost-effectiveness test, then they remain enrolled in direct coverage BadgerCare. Several factors are considered when determining cost-effectiveness, including the cost to buy into the employer plan, wraparound costs (if any), and administrative costs.

The entire eligibility review process, which includes first determining an applicant's eligibility for BadgerCare, must be completed within 56 days. Like Massachusetts, the family is eligible for fee-for-service benefits while their eligibility is being determined, with enrollment taking place at the earliest available open enrollment period of the employer plan. If the state does not hear back from the employer within 56 days, the family is enrolled in a BadgerCare HMO or left in fee-for-service.

Payment Processes. As in Massachusetts, coverage under HIPP begins when the family submits proof of enrollment in their employer plan. In Wisconsin, a pay stub is required and must indicate that a premium was deducted from the employee's paycheck. Reimbursement is then made to either the employer or the employee, depending which arrangement is preferred. In most cases, the state sends the sub-

sidy directly to the employee for the cost of the premium deducted by the employer. Continued enrollment in ESI is monitored through the submission of pay stubs on a monthly basis. There are no copayments for BadgerCare participants enrolled in managed care, including participants in HIPP.

Strategies for Addressing Crowd Out. One of the primary goals of HIPP is to "supplement, not supplant, employer insurance pools" (Wisconsin Division of Health Care Financing 2001b). To ensure that this occurs, the state enacted several measures to address crowd out including a six-month waiting period and a 40 percent employer contribution minimum.

As described above, Wisconsin's 80 percent maximum employer contribution level is one strategy to limit crowd out—lawmakers believed it would prevent families with seemingly generous ESI offers from taking advantage of the program. However, state program officials felt this maximum contribution level may be problematic because it doesn't adequately determine whether the family's ESI offer is affordable—for example, the family may only be required to contribute 19 percent toward the cost of their coverage but have a very high deductible. Program officials speculated that the potential for public coverage expansions to crowd out private coverage would need to be disproved before lawmakers eliminate the 80 percent contribution maximum. Although there has been little anecdotal evidence of crowd out, no conclusive quantitative estimates have, as yet, disputed or diminished crowd out concerns among Wisconsin's lawmakers.

To limit the ability of employers to drop ESI for their lower-income employees who might qualify for BadgerCare, state law also prohibits employers from dropping or limiting ESI coverage to a subset of their employees. In addition, Wisconsin is in the process of evaluating the impact of BadgerCare policies on crowd out, looking specifically at the number of BadgerCare applications denied because of other health insurance coverage or coverage in the previous three months and the number of enrollees terminated because of other health insurance indicators found as a result of matching enrollment data with information submitted by local and national insurance carriers that sell or issue health care policies to Wisconsin residents. Thus far, program officials believe that BadgerCare, including the HIPP program, is reaching those families who are most likely to be uninsured—over 90 percent of families enrolled in BadgerCare have incomes below 150 percent of FPL.

Lessons Learned

It has been Wisconsin's experience that after all the steps are completed for the eligibility determination, a very small percent of the applicants are enrolled in the HIPP program. As of October 31, 2001, a total of 64,128 EVICs were returned and screened for premium assistance eligibility. Yet enrollment at that time consisted of just 47 families, working for roughly 27 employers. The participating employers were a mix of both large and small establishments, but most had fewer than 50 employees. Another 130 families were approved, but needed to wait for their employers' open enrollment period before enrolling in HIPP. Participation in HIPP has been growing over time, but is still a very small portion of BadgerCare's enrollment of over 26,000 children (Smith et al. 2001). Program officials attribute

low enrollment to several factors (Wisconsin Division of Health Care Financing 2001b):

- Loss or frequent changes in employment result in few recipients being able to enroll in HIPP. Of the returned EVIC forms, about 22 percent indicate that the employer no longer employs the applicant and about 14 percent no longer qualify.
- Few employers offer dependent coverage to low-income families, and those that do provide benefits too limited to qualify for HIPP. Of those applicants reviewed for HIPP eligibility, over half either do not have offers for family health coverage or the health plans do not meet the SCHIP benefit standards (and it would be difficult to provide wraparound coverage of these benefits and meet cost-effectiveness standards).
- Of those applicants with ESI, approximately 75 percent work in establishments that do not meet the employer contribution requirements. Approximately 20 percent of the cases reviewed had employers who contributed 50–59 percent, but these cases could not be considered owing to the previous 60 percent requirement. The minimum requirement is now 40 percent. (In about 6 percent of cases, the employer contributed more than 80 percent of the cost of coverage.)

In addition to these specific barriers to HIPP enrollment, Wisconsin officials noted that the program is very labor intensive from an administrative standpoint—requiring an intensive eligibility determination process that not only reviews family information, but also requires employer cooperation in submitting health plan information. State officials stressed the importance of fostering familiarity with the program among businesses and noted that, in general, the program has seen a good response rate from employers requested to return EVIC forms—as of July 2001, the HIPP program mailed over 71,000 EVIC forms to collect information about employer-sponsored plans and had a 69 percent return rate. With employer familiarity of the program increasing, the response rate for EVIC forms mailed out in September 2001 was roughly 90 percent. Wisconsin, in contrast to Massachusetts, has found that maintaining an employer database has been helpful in processing the employer health plan information. The database has served as a valuable tool in collecting information on employers likely to participate in the program and providing contact information for follow-up and outreach efforts.

State officials hope that the change in November 2001, from a 60 percent employer contribution requirement to a 40 percent requirement, will improve HIPP's enrollment. Although eliminating the 80 percent maximum contribution level might further reduce the barriers to the HIPP program enrollment, state officials do not believe that it is currently a political reality given the lack of evidence supporting or disputing crowd out concerns. In addition, officials would like to see eligibility for HIPP count as a "qualifying event" for immediate enrollment in employer-sponsored coverage (just as marriage or having a child currently enables families to immediately qualify for ESI), rather than wait for an open enrollment period. However, state legislation would be required to make this change. As noted earlier, as of October 2001, approximately 130 families were eligible for HIPP, but needed to wait for their employers' open enrollment period before receiving premium assistance and joining an ESI plan.

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Overall, Wisconsin program officials believe that the HIPP program has been a worthwhile endeavor. However, they noted that premium assistance programs are "not for the faint of heart" and recommended that other states considering implementing such programs do so with long-term, rather than short-term, goals in mind due to the program's intense start-up and slow enrollment buildup. Program officials believe that the HIPP program supports the long-term goals of promoting access to health care, providing continuity of care as families move to private insurance as their income increases, supplementing employer insurance pools, and maximizing the use of private support for BadgerCare (Wisconsin Division of Health Care Financing 2001b).

Mississippi

Mississippi is the third state granted approval to implement a premium assistance program under SCHIP, but the program has not yet been enacted. Because the state has no implementation experience, the following discussion briefly summarizes the reasons why Mississippi officials sought to create a premium assistance program and highlights the similarities and differences between Mississippi's planned effort and the programs in Massachusetts and Wisconsin.

Overview of Program

Shortly after the passage of Title XXI, Mississippi established the Children's Health Insurance Commission to determine how the state would expand children's health insurance coverage. In addition to developing the state's plan for a Medicaid expansion and the creation of a separate children's health insurance program, the Commission became interested in premium assistance—primarily as a means of deterring crowd out. The Commission believed that by offering families subsidies to purchase available ESI, they would be less likely to substitute public coverage for private insurance.

Despite receiving approval in February 1999, Mississippi has indefinitely postponed implementation of its premium assistance program largely due to the many challenges presented by its insurance market. Working with its contractor, Blue Cross Blue Shield of Mississippi, state officials estimated that only 10–15 percent of employer plans would meet all criteria to qualify for premium assistance under SCHIP.[24] More generally, Mississippi has a lower than average rate of employer-sponsored insurance—57.3 percent for children compared with 66.7 percent nationally, and 65.9 percent for adults compared with 72.3 percent nationally (Kenney et al. 2000; Zuckerman et al. 2000). In 1999, 18 percent of children were uninsured compared with 3.4 percent in Massachusetts and 7.4 percent in Wisconsin (Kenney et al. 2000; Zuckerman et al. 2000).

Key Program Design Characteristics

As it is currently planned, Mississippi's premium assistance program possesses several similarities with, but also distinct differences from, Massachusetts' and Wiscon-

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sin's programs. The planned features of Mississippi's program that are similar to Wisconsin's and/or Massachusetts' include:

- **Targeting outreach efforts to employers.** Leaders of the business associations involved in the initial development of the program were suspicious of state government becoming involved with the private insurance market. However, they were influenced by the idea that providing premium assistance would benefit workers and lead to improved job satisfaction. State officials in Mississippi, as in Massachusetts and Wisconsin, expect that it will be important to reach out to employer associations and business leaders again to gain their trust and understanding of the program.

- **Employer contribution level.** As with Massachusetts, Mississippi received approval to lower the 60 percent employer contribution and established a 50 percent level instead. Nevertheless, it is expected that this contribution level would still prevent the vast majority of employer plans from qualifying.

- **Subsidy paid directly to family.** Mississippi's original premium assistance plan would have directed the subsidy to employers in advance of when the premium deductions would be taken from employees' salaries. However, state officials now think they would pay subsidies directly to families, rather than employers. The primary reason for this change would be to ensure that families' receipt of subsidies remains confidential. In addition, subsidizing the family directly would reduce the anticipated administrative burden on the employer, making the program invisible to employers.

- **Waiting period.** As with Wisconsin, Mississippi's program has a six-month waiting period. Mississippi initially requested a three-month waiting period for the program, but CMS would not waive the federally required six-month waiting period for premium assistance programs because of its concern about crowd out. State officials believe that this policy will be relatively ineffective since families eligible for ESI subsidies have the option of enrolling in the Mississippi Health Benefits Program, which has no waiting period.

There are also some interesting differences between Mississippi and the programs in Massachusetts and Wisconsin:

- **Voluntary enrollment due to benefit package differences.** Mississippi's separate children's health insurance program provides dental, vision, and hearing services in addition to benchmark equivalent coverage provided by the State and Public Employer's Health Insurance Plan. However, the state will not require that employers provide these additional benefits for the premium assistance program because most plans would not meet the requirement. Mississippi will not provide wraparound coverage for dental, vision, and hearing benefits because the additional cost would likely preclude many employer plans from passing the cost-effectiveness test. Consequently, in order to address the potential disparity between the premium assistance program benefit and those of Medicaid or the Mississippi Health Benefits Program, enrollment in the premium assistance program will be voluntary—families with access to qualifying ESI will have a choice

of enrolling in the premium assistance program or enrolling in direct public coverage (Medicaid or SCHIP).

- **Requiring families to supply information on their ESI to minimize burden on employers.** In contrast to Massachusetts and Wisconsin, Mississippi's premium assistance program will make it the employee's responsibility to obtain information about their employer's plan. The employee will need to obtain information regarding the type of benefits the employer offers and the premium—both employer and employee shares.
- **No premium.** In contrast to Massachusetts and Wisconsin, Mississippi will not require participants to pay premiums. During the development of the premium assistance plan, there was general agreement that cost sharing should be in the form of copayments at the point of service and not in the form of premiums. Mississippi believes that premiums could create a barrier to enrollment or disrupt continuity of care if coverage is terminated because of nonpayment.

Although Mississippi's premium assistance program is on the "back burner" for the time being, state officials are still optimistic that the program will eventually be implemented, perhaps when enrollment growth in Medicaid and the Mississippi Health Benefits Program slows or plateaus. When implementation of the program becomes imminent, state officials may attempt to seek federal approval to amend the 50 percent employer contribution requirement—in light of the recent changes in federal regulations—and request a reduced level. Mississippi officials were pleased that CMS eliminated the 60 percent employer contribution level requirement, but believe that still greater regulatory flexibility is needed to encourage more states to design and implement premium assistance programs.

Discussion

States' overall lack of pursuit of premium assistance programs contrasts sharply with their unprecedented efforts to expand coverage under SCHIP. While all fifty states plus the District of Columbia have implemented direct coverage children's health insurance programs, only seven states have received federal approval for premium assistance programs: Massachusetts, Maryland, Mississippi, New Jersey, Wisconsin, Wyoming, and Virginia. Of these, only Massachusetts, Maryland, Wisconsin, and Virginia have actually implemented the programs at the time of this writing. According to state officials, this limited response is partly because of federal requirements that make premium assistance programs administratively burdensome, and the fact that relatively small numbers of children potentially eligible for such programs. For example, Colorado considered designing a premium assistance program until a feasibility study determined that even if federal regulations were eliminated, only 4,500 children would be eligible and the program would require an annual administrative budget of over $1 million (Schulte et al. 2001).

Nevertheless, there are a number of reasons why states might want to expand children's health insurance through premium assistance programs. Among the three

states examined in this study, the primary reasons for subsidizing employer-sponsored insurance were similar, and included

- interest in expanding health coverage to working families who could not afford to take up offers of employer-sponsored insurance;
- the opportunity to leverage private funding "already in the system" to better maximize the use of financial resources available for health coverage; and
- to deter the likelihood that SCHIP would crowd out private health insurance coverage.

This last rationale is particularly interesting in light of the federal concern that premium assistance programs may pose a *greater* potential for crowd out than direct coverage public programs. Despite the federal concern for crowd out and subsequently stringent regulations for implementing premium assistance programs, all three states viewed such programs as a means of encouraging families to take up or maintain ESI. In addition, states viewed premium assistance as a vehicle for supporting an employer commitment to ESI. In Massachusetts for example, the premium assistance program was actually noted as a specific strategy to deter crowd in the state's SCHIP plan.

Although all three states believed in premium assistance as an alternative means of providing health coverage, the experiences of Massachusetts and Wisconsin suggest that subsidizing ESI programs is administratively intense and according to one official, "not for the faint of heart." The premium assistance programs examined in this study impart several findings that may be useful to other states considering such programs.

- **Outreach.** Although states have recently gained considerable experience in targeting public program outreach efforts to families and community-based organizations, premium assistance programs pose a new outreach challenge to states as they directly involve and require the cooperation of employers. In order to succeed in implementing premium assistance programs, state officials noted the importance of augmenting broader SCHIP outreach campaigns with specific efforts to target employers. Specifically, states noted that employers and employer associations needed to be involved in the design phase to address their concerns and ensure participation. In addition, because employer awareness of the program facilitates the ESI investigation part of eligibility determination, Massachusetts and Wisconsin stressed the importance of ongoing employer outreach.
- **Enrollment.** Wisconsin and Massachusetts have learned they must engage in complex, time-consuming, and challenging processes for enrolling children (and often their parents) into premium assistance programs. Typically these processes involve determining when families have access to ESI, reviewing and comparing the benefit packages, determining employer contributions to the overall cost of coverage, and calculating whether it is more cost-effective to subsidize ESI or enroll the children into direct coverage SCHIP programs. Although program officials thought removing the employer contribution requirement would make it easier for families to qualify for premium assistance, they were doubtful that it would have much impact on states' interest in designing such programs under

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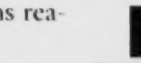
SCHIP owing to the administrative difficulties of eligibility determination. In particular, state officials noted the complexity of investigating employer benefit packages and comparing them to the state-selected SCHIP benchmark—a process that often resulted in families not qualifying for premium assistance under SCHIP. In Wisconsin, over half of the applications reviewed for HIPP eligibility fail to meet the SCHIP benchmark standards—largely because of plans not covering such benefits as dental and vision. States may, however, have additional flexibility in investigating benefit packages if they opt for "Secretary-approved" coverage as the benefit benchmark.[25] Moreover, states pointed out that they must factor in the cost of providing wraparound benefits when determining whether it is cost-effective to subsidize the applicant's ESI premium.

- **Outcomes.** Massachusetts and Wisconsin believe their premium assistance programs are worthwhile endeavors, but caution other states considering such programs from being overly optimistic about initial enrollment. As of October 31, 2001, enrollment in Wisconsin's HIPP program consisted of 47 families, a very small number relative to Wisconsin's overall SCHIP enrollment. As of September 30, 2001, the total number of children receiving premium assistance in Massachusetts was 4,433, but only 16 percent were funded through SCHIP because of the stringency of SCHIP's eligibility criteria.

However, despite relatively small numbers of enrolled families, Massachusetts and Wisconsin officials are comfortable with the progress their programs have made thus far, even given the additional outreach efforts required and administrative difficulties. They have placed these programs in the broader context of expanding health coverage and believe that partnering with the private sector "is the right thing to do," and will have long-term benefits. Moreover, Massachusetts points to the number of children receiving Medicaid-funded premium assistance (3,733 children) as evidence that federal regulations hinder the enrollment of SCHIP-funded participants (700 children). Although Mississippi has yet to implement its program, state officials are optimistic that it is still a strategy worth pursuing as a means of expanding coverage and stemming crowd out.

The importance and relevance of premium assistance programs may grow in the year or years ahead—the U.S. has experienced its first recession in over a decade, unemployment has been exacerbated in the aftermath of the September 11 terrorist attacks, and health insurance premiums increased 11 percent between September 2000 and September 2001 (Kaiser/HRET 2001). Thus, with increased numbers of families struggling, and perhaps failing, to afford their ESI premium contributions, government assistance in purchasing private coverage may be an effective means of stemming the number of low-income families that become uninsured because they decline offers of costly employer-sponsored insurance. It is also important, however, to keep in mind that premium assistance programs will not help those families without coverage offers or those whose employers contribute so little to the cost of coverage that it is more cost-effective to enroll the child in a direct-coverage program than subsidize ESI.

Considering the administrative complexity associated with premium assistance and the small overall effect witnessed in Massachusetts and Wisconsin, it seems rea-



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sonable for states to question whether this is an efficient strategy for reducing rates of uninsurance among low-income children. At this time, it appears unlikely that federal regulations for premium assistance under SCHIP will be further relaxed given the uncertainty and lack of data on crowd out, although states do have more flexibility in designing premium assistance programs under the new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. Beyond this, the complexity of coordinating coverage with employers, the shifting nature of low-income families' employment status, and the dynamic nature of employer-sponsored insurance, remain potential barriers to enacting such programs (Polzer 2000). States will need to weigh these negatives against the positive impact premium assistance programs may have for expanding or maintaining health insurance coverage within the employer-based market. Unfortunately, these complex considerations must occur within the current recessionary environment—when increased demands for subsidies are coupled with declining state revenues and rising Medicaid costs.

Notes

1. Before the rules published on January 11, 2001, states wishing to provide family coverage needed to request to do so in their state plan under the authority at section 2105(c)(3) of the Act as a "family coverage waiver." The interim final rule published June 25, 2001 removed the word "waiver" from the section heading in the regulations regarding family coverage. The final rules published on January 11, 2001, clarified that states no longer needed to request this authority if the employee's premium is not subsidized and there is no intention on the state's part to cover family members other than targeted low-income children. In such cases, CMS also clarified that the regulatory requirements in the final rules apply to only the targeted low-income children. Essentially, states are now permitted to incidentally cover parents in premium assistance programs without submitting an amendment—meaning that while there is no explicit intent to cover parents, they are incidentally covered because the premium subsidy for the child(ren) is for family coverage.

2. Other states that received federal approval in 2001 include Maryland, New Jersey, Virginia, and Wyoming.

3. The final regulations eliminated the 60 percent requirement and allowed states to suggest a minimum employer contribution requirement reflective of their insurance market, as long as cost-effectiveness is proven.

4. The federal interim final rules, published June 25, 2001, noted that states need not count adult family members' cost-sharing toward the cumulative cost-sharing cap when providing family coverage.

5. CMS made revisions to the proposed final rules and issued an interim final rule for SCHIP on June 25, 2001. No revisions were made to the proposed final rules on subsidizing ESI. The revised provisions, as well as the unchanged provisions in the January 2001 rule, became effective on August 25, 2001.

6. The process of comparing employers' health plans involves comparing those plans to the type of health benefits coverage permitted under section 2103 of the Act that the state has chosen, whether it be one of the statutory benchmark plans, a benchmark equivalent plan, existing comprehensive state-based coverage, or secretary-approved coverage.

7. Before the rules published on January 11, 2001, states wishing to provide family coverage needed to request to do so in their state plan under the authority at section 2105(c)(3) of the Act as a "family coverage waiver." See note 1.

8. The final regulations eliminated the 60 percent requirement and allow states to suggest a minimum employer contribution requirement reflective of their insurance market.

9. The federal interim final rules, published June 25, 2001, noted that states need not count adult family members' cost-sharing toward the cumulative cost-sharing cap when providing family coverage.

10. States may also subsidize ESI through the Medicaid program under Section 1906 of the Social Security Act, which allows states to pay a low-income worker's share of the premium for employer-sponsored health insurance along with any cost-sharing, providing that it is cost-effective to do so.

11. Other states that received federal approval in 2001 include Maryland, New Jersey, Virginia, and Wyoming.

12. See note 1.

13. Florida proposed that small businesses (less than 50 employees) be required to contribute 24 percent toward the cost of premiums and large businesses 40 percent toward the cost of premiums.

14. CMS made revisions to the proposed final rules and issued an interim final rule for SCHIP on June 25, 2001. The effective date of these rules was August 25, 2001. No revisions were made to the proposed final rules on subsidizing ESI, with the exception that states need not count adult family members' cost sharing toward the cumulative cost-sharing cap when providing family coverage.

15. Massachusetts has a plan amendment pending federal approval that would change its SCHIP benchmark benefit into Secretary-approved coverage, that is, the benefit coverage for children offered under its approved Title XIX section 1115 demonstration waiver. Massachusetts expects the less-stringent benefit benchmark will allow for more children to qualify for SCHIP-funded premium assistance.

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16. Although the federal requirements originally indicated that employers need to contribute 60 percent of the cost of coverage, HCFA allowed Massachusetts to require that employers contribute 50 percent of the cost of coverage because it was authorized under its 1115 waiver.

17. The incentive is a yearly subsidy paid on a monthly basis of $400 per individual, $800 per couple, and $1,000 per family toward the employer's health insurance costs for each qualified employee. Businesses are eligible if they employ 50 or fewer full-time workers; offer comprehensive health insurance coverage to workers; and contribute at least 50 percent of the premium. As of September 2000, approximately 1,620 employers were participating and 60 percent were offering insurance for the first time (Silow-Carroll et al. 2001).

18. These children are covered using Title XIX funding under the Title XXI requirement that targeted low income children must be uninsured.

19. Assistance with cost-sharing is provided if the child was uninsured at the time of application for MassHealth and the copay, coinsurance, or deductible was incurred as the result of a well-child visit or when the family's out-of-pocket expenses exceed 5 percent of their income. Once families' out-of-pocket expenses exceed 5 percent of income, families may submit the bill to DMA for processing or pay the physician up-front and then DMA would reimburse the family for the expense. The Premium Assistance program for adults does not provide assistance with cost-sharing.

20. Once enrolled, families may remain in the program until their income exceeds 200 percent of FPL, providing that there is no cap on enrollment.

21. BadgerCare is the name of both Wisconsin's Medicaid and SCHIP programs under Section 1115 authority.

22. Wisconsin began the first phase of their expansion in April 1999 when they began enrolling children age 15 to 18 into BadgerCare.

23. Premium rises with every $500 increase in annual family income.

24. Blue Cross Blue Shield is the largest insurer in the state and was selected to help administer the program. CMS lowered the 60 percent contribution threshold to 50 percent for Mississippi based on evidence that a significant number of employers did not meet the 60 percent threshold.

25. For example, Massachusetts recently received approval to change its SCHIP benchmark to "Secretary-approved" coverage. Also, Wyoming received approval to provide "Secretary-approved" coverage for its premium assistance program that consisted of the state-mandated set of "basic benefits" required of its health insurers. Because the health plans participating in Wyoming's premium assistance program would by state law meet these basic benefit requirements, the state will not need to engage in the complex task of benefit comparison. Massachusetts is also hoping that amending its benchmark to "Secretary-approved" coverage will simplify the benefit investigation process and enable more children to qualify for SCHIP funded premium assistance.

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